

DoD/VA Clinical Practice Guideline for the Assessment and Management of the Suicidal Patient

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DISCLOSURE

- I have no financial relationships to disclose.



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Intent of the Guidelines

- Not intended to be a standard of care
- Reduce practice variation
- Provide evidence-based recommendations
- Identify outcome measures

My Premise

- Brain is an important organ
- Mental Illness exists and is not the individual's "fault"
- Suicide is a behavior caused by a complex interaction of psychiatric & psychologic factors
- Biases aside, goal is to decrease prevalence

Review of Data

- 33.3% of suicide decedents + for EtOH, 23% for antidepressants, 20.8% for opiates
- Veterans account for 20% of US suicides
- 18-22/day
- Military-specific suicide data assists clinicians
- THOROUGH assessment improves management

Knowns

- “lack of strong evidence for any interventions in preventing suicide and suicide attempts”
- >50% suicides have had contact with primary care month before, opening opportunity
- Suicide remains rare despite rate increases in Active duty
- Difficult to research

Nomenclature

- Suicidal Self-Directed Violence
- Non-Suicidal Self-Directed Violence
- Undetermined Self-Directed Violence

Organization of the Guideline

- Module A: *Assessment and Determination* of the Risk for Suicide
- Module B: *Initial Management* of the Patient at Risk for Suicide
- Module C: *Treatment* of the Patient at Risk for Suicide
- Module D: *Followup and Monitoring* of the Patient at Risk for Suicide

Detection, Recognition & Referral

- Patients with suicidal ideation should receive a complete suicide risk assessment
- **CPG NOT for general population**
- Patients with psychiatric illness or SUD should be asked about suicidal thoughts and behavior directly
- Referral to specialty BH should be based on the level of risk and the available resources
- When risk is UNDETERMINED, the patient should be immediately referred for an evaluation

Who should be assessed by CPG?

- Axis I disorder or medical condition (TBI, pain, sleep dysfunction)
- + on PDHRA
- Reports suicidal thoughts
- Referred by command, clergy, family, unit due to behavioral concerns
- Hx suicide attempt or recent SDV

Suicide Continuum

- Thoughts, wish to die, intention to act, plan
- Minutes to years
- Worrisome warning signs: Suicidal communication, seeking access or recent use of lethal means, preparations for suicide
- No individual is “no” risk for suicide- underestimation is high risk practice

Risk Stratification

- Acute vs chronic
- High, intermediate, low
- Risk and protective factors
 - Accumulation of risk factors insufficient
- Level of risk guides the clinical intervention

Assessment

- SI, intent, plan
 - Onset, duration, frequency, etc
- Risk and protective factors
- Warning signs?
- Remain empathetic, objective, non-judgmental

How to Ask

- SI
 - With all of this, have you been experiencing any thoughts of killing yourself?
- Plan: if yes, review preparatroy behavior
 - Have you done anything to carry out the plan?
- Intent
 - Do you intend to try to kill yourself?
 - How likely do you think it is you will carry out your plan?

High Acute Risk of Suicide Attempt

Indicators of Suicide Risk	Contributing Factors	Initial Action Based on Risk
Persistent suicidal ideation or thoughts Strong intention to act or plan Not able to control impulse Recent suicide attempt or preparatory behavior	Acute state of mental disorders or acute psychiatric symptoms Acute precipitating events Inadequate protective factors	Maintain direct observational control of the patient Limit access to lethal means Transport immediately to urgent/emergency care for hospitalization

Intermediate Acute Risk of Suicide Attempt

Indicators of Suicide Risk	Contributing Factors	Initial Action Based on Risk
Current suicidal ideation or thoughts No intention to act Able to control the impulse No recent suicide attempt or rehearsal to act	Acute state of mental disorders or acute psychiatric symptoms Existence of warning signs or risk factors Limited protective factors	Refer to Behavioral Health provider for complete evaluations and interventions Contact Behavioral Health provider to determine acuity of referral Limit access to lethal means

Low Acute Risk of Suicide Attempt

Indicators of Suicide Risk	Contributing Factors	Initial Action Based on Risk
Recent suicidal ideation or thoughts No intention to act or plan Able to control the impulse No recent rehearsing or planning a suicide act No previous attempt	Existence of protective factors AND Limited risk factors	Consider consultation with Behavioral Health to determine need for referral and treatment Treat presenting problems Address safety issues Document care and rationale for action

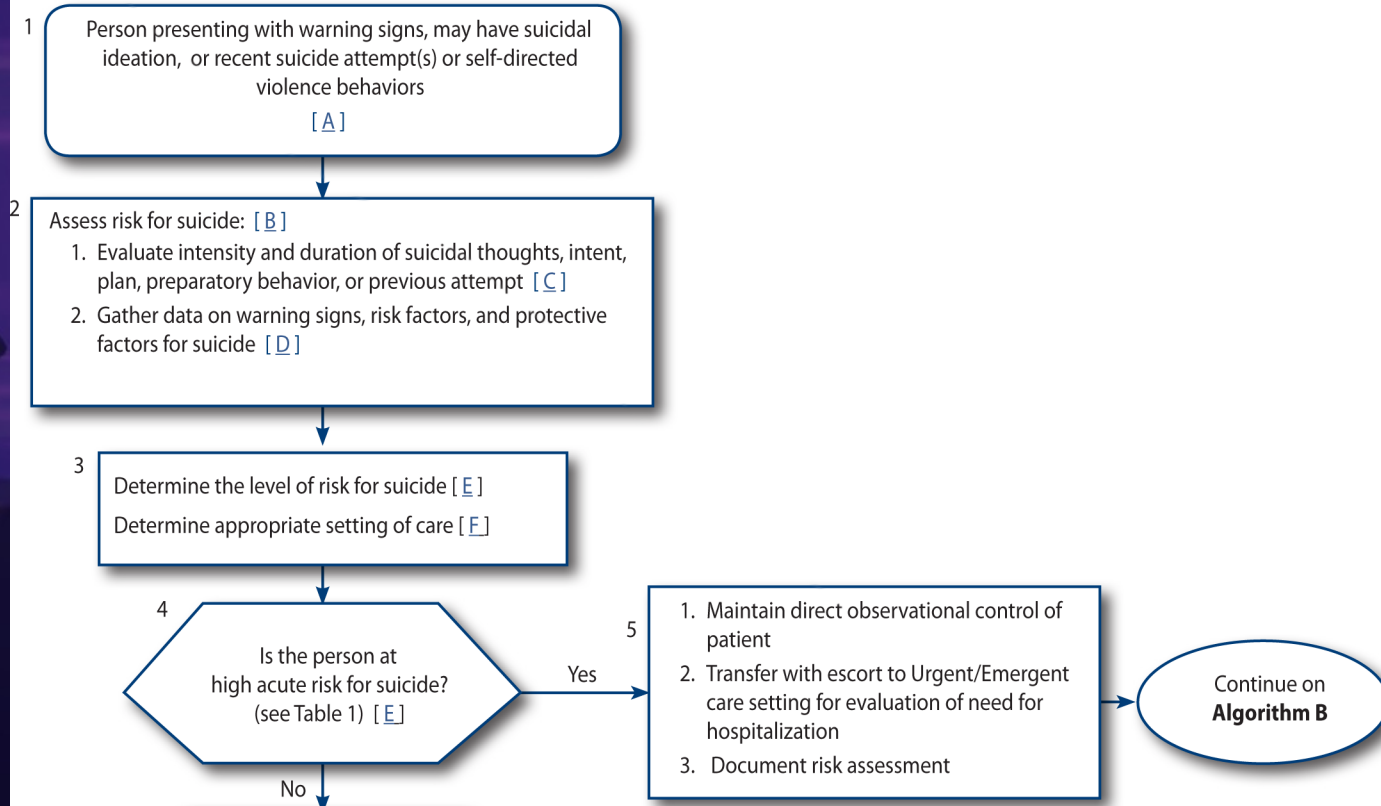
Risk Assessment Instruments

- Should not be based on any single assessment instrument alone
- Cannot replace a clinical evaluation
- Should reflect the understanding that an absolute risk for suicide cannot be predicted with certainty
- There is insufficient evidence to recommend any specific measurement scale to determine suicide risk

Risk Assessment Instruments

- Inform risk stratification
- Support clinical decision-making
- Determine the level of intervention and indication for referral
- Allow monitoring of risk level over time
- Serve as the foundation for clinical documentation
- Facilitate consistent data collection for process improvement

ALGORITHM A: ASSESSMENT AND MANAGEMENT OF RISK FOR SUICIDE IN PRIMARY CARE



Case Study: Presentation

- 47 y/o female, Army NCO for military funeral honors for Veterans presents to PCM with c/o anxiety and reports 'feeling depressed', brought in by her sister
- Elated mood for 6 weeks, then began having "bad outcomes" for the prior month and felt she was losing her ability to cope
- PHQ2 was negative when questioned alone

Case Study: Presentation

- Feels as if she is not responding to her medications for depression/anxiety (Fluoxetine/Diazepam)
- Last night, she contemplated taking entire bottle of Diazepam with the intent to “sleep and not wake up”
- Interrupted by her sister

Case Study: Medical History

- Migraine headaches
- Non-cardiac chest pain
- Endometriosis
- Right breast lump/mass
- Anxiety treated by PCM
- Current Medications: Topiramate, Zomatriptan, Fluoxetine, Diazepam, Acetaminophen

Case Study: Social History

- She has buried ten people whom she personally knew, and one was her own soldier
- Tobacco – 30 pack years, recently quit smoking
- Husband suicide 4 years ago
- Father and mother were alcoholics
- No prior suicide attempts
- Admits to increased alcohol use

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Person has current suicidal thoughts, ideation
presumed to be at HIGH to INTERMEDIATE level
of ACUTE RISK for suicide

15

Complete psychosocial evaluation
by a Behavior Health provider
[E-3]
Document risk assessment

16

Are there indications for
admission ?
[F-3]

Yes

17

Hospitalize - consider involuntary
commitment if patient refuses [F-3]

- Stabilize psychiatric conditions
- Monitor Safety
- Consider initiating suicide-focused therapies

No

18

Can the patient be managed in
less restrictive environment?
All the following are met:
- No current suicide intent, AND
- Psychiatric symptoms are stable, AND
- Able and willing to follow Safety Plan
[F-2]

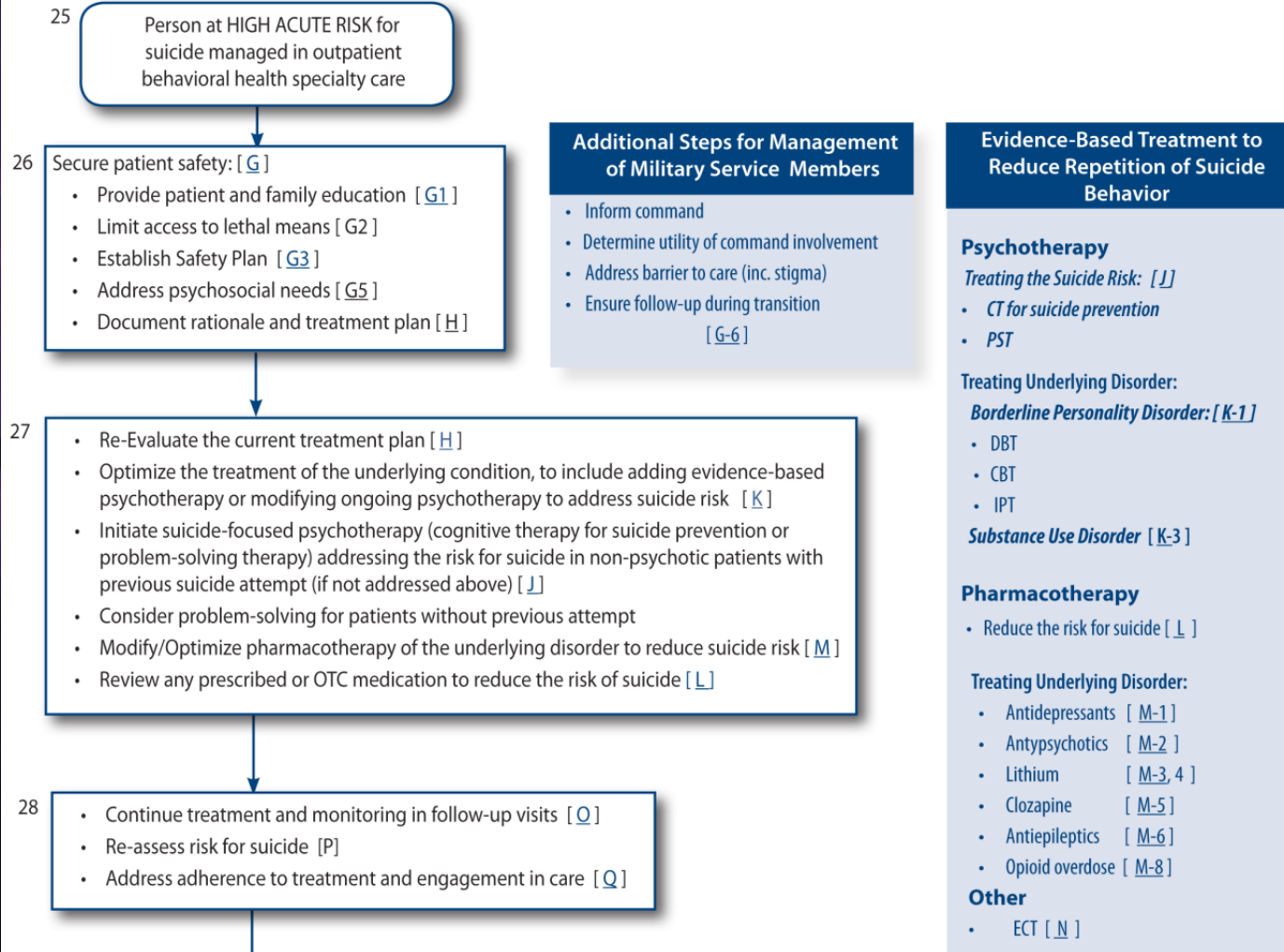
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Yes

Refer to appropriate setting of care
for treatment and follow-up
[F-1; F-5]

Case Study: Initial Management

- High acute risk
- Same day consultation with BH provider
- Unable to engage in safety planning
- Direct psychiatric admission
- Command notified



- Continue treatment and monitoring in follow-up visits [[Q](#)]
- Re-assess risk for suicide [P]
- Address adherence to treatment and engagement in care [[Q](#)]

29 Patient discontinues or refuses care? [[Q](#)]

Y

30

Manage according to facility requirements for re-locating and re-engaging

No

31 Patient's risk for suicide decreased to low or below?

Y

32

- Continue routine care [[R](#)]
- Periodically re-assess risk for suicide and monitor for relapse [[S](#)]

No

33

Return to **Algorithm B**
Assessing appropriate setting of care

Interventions to Improve Adherence

- Case- Care Management [[Q-1](#)]
- Facilitating access to care [[Q-2](#)]
- Mailing caring letters/postcards [[Q-3](#)]
- Telephone contact [[Q-4](#)]
- Outreach (home visit) [[Q-5](#)]
- Assertive outreach [[Q-6](#)]
- Counseling and other psychosocial interventions [[Q-7](#)]

Management

RECOMMENDATIONS

1. Consider hospitalization for patients at high risk for suicide who need crisis intervention, intensive structure and supervision to ensure safety, management of complex diagnosis, delivery of intensive therapeutic procedures.
2. The inpatient psychiatric hospital setting is particularly suitable for the treatment of acute rather than chronic suicidality.
3. Individualized treatment plan should be determined to meet the patient's needs and aimed to allow as much self-control and autonomy as possible, balanced against the risk level.
4. Although suicidality may persist, the treatment goal is to transition the patient toward a less restrictive environment based on clinical improvement and the assessment that the suicide risk has been reduced.

Indications for Admission

RECOMMENDATIONS

1. Any patient with suicidal intent or behavior who cannot be maintained in a less restrictive environment requires hospitalization in order to provide an optimal controlled environment to maintain the patient's safety and initiate treatment.
2. A complete biopsychosocial assessment should be performed upon hospitalization to determine all direct and indirect contributing factors to suicidal thoughts and behaviors. Patient and family education should be provided on techniques to manage these factors.

Goals of Hospitalization

- Diagnostic clarification to ensure an underlying psychiatric disorder and any co-morbid disorders can be adequately treated
- Increasing level of safety for the patient by being in a more closely controlled environment with increased supervision
- Initiating treatment after a timely assessment
- Responsive alterations of treatment for co-occurring disorders and/or treatment side effects, as indicated
- Comprehensive discharge planning

Safety Planning

- Individualized written plan oriented to no-harm decision
- Stepwise approach to managing internal/external triggers to suicidal thought
- Identifies coping strategies
- External resources
- Restriction of means
- Documented in the EMR

	Evidence	Source	LE	QE	SR
1.	Brief Safety planning interventions (SPI) to reduce suicide risk may be especially useful	Stanley & Brown, 2012	III	Low	I
2.	Adapted SPI to veterans presenting to ER experiencing suicide risk doubled the rate of patient compliance with follow up care	Knox et al., 2012 [SAFE-VET]	III	Low	I

contracts. A safety plan is a preferred strategy for preventing suicide.

RECOMMENDATIONS

- 1 Recommend against the use of no-suicide contracts as intervention to prevent future suicide in patients at high risk for suicide.
- 2 Patient management should include a comprehensive evaluation of current risk factors and warning signs for suicide, a personalized safety plan that best anticipates triggers for future suicidal thoughts and collaboratively develops coping strategies that make sense for the individual patient.

Limiting Access to Lethal Means

RECOMMENDATIONS

Consider ways to restrict access to lethal means that Service members/Veterans could use to take their own lives. This includes, among others, restriction of access to firearms and ammunition, safer prescribing and dispensing of medications to prevent intentional overdoses, and modifying the environment of care in clinical settings to prevent fatal hangings.

1. Provide education about actions to reduce associated risks and measures to limit the availability of means with emphasis on more lethal methods available to the patient:
 - a. **Fire Arms:** For patients at highest risk, exercise extreme diligence to ensure firearms are made inaccessible to the patient. For all patients at intermediate to high risk of suicide, discuss the possibility of safe storage of firearms with the patient, command, and family. (e.g., lock firearms up, use trigger locks or store firearms at the military armory, at a friend's home, or local police station. Store ammunition separately.)
 - b. **Medications:** When clinically possible, include limiting access to medications that carry risk for suicide, at least during the periods when patient is at imminent or high risk for suicide. This may include prescribing limited quantities, supplying the medication in blister packaging, providing printed warnings about the dangers of overdose, or ensuring that currently prescribed medications are actively controlled by a responsible party.
 - c. **Household poisons:** Many forms of chemical poisons are freely available to buy, especially agricultural and household chemicals. Many of these are highly toxic.

Firearms

- US, 1999-2004: 54.6% suicides attributed to firearms (CDC)
- >50% military suicides had firearm in home (2011)
- DODSER Data, 2011: 59% firearm, hanging 20%
- **Leading cause for females as well as males**

Means Restriction

RECOMMENDATIONS

1. Consider ways to restrict access to lethal means that service members/veterans could use to take their own lives. This includes the restriction of access by:
 - Securing firearms and ammunition,
 - Limit supply of medications prescribed
 - Use of blister packs for lethal medications to prevent intentional overdoses,
 - Environment of Care interventions on Inpatient Psychiatric Units

Treatment Considerations

- Treat underlying conditions optimally
- Modify treatment for the underlying conditions to address the risk of suicide
- Complement treatment of underlying conditions with treatment that directly addresses the risk of suicide

Treatment Considerations

- Use evidence-based treatment (CPGs) for mental health or medical conditions
- Involve family/unit members when the patient consents

Pharmacotherapy Recommendations (General)

- No diagnosis = No medication
- New onset suicidal behaviors = Review medications
- Medications to treat the underlying mental disorder
- Consider the lethality of prescribed medications

Psychotherapies

- Primary goal is to teach suicidal patients and help them to internalize the truth that:

SUICIDE IS NOT THE ONLY OPTION!

Psychotherapies Addressing Suicide Risk

Suicide-focused psychotherapies should be included in the treatment plan of high risk patients, if the risk is not adequately addressed by psychotherapy specific to the underlying condition.

Optimizing Adherence

Recommendations

- Engage patient and, where appropriate, available support systems (e.g., family, unit, friends).
- Care should be coordinated by an interdisciplinary team and communicated with the patient

Military-Specific Recommendations

If HIGH acute risk, INVOLVE COMMAND!

- Recovery
- Reintegration with unit
- Share recommendations
 - Duty restrictions
 - Firearms access
 - Deployment

Military-Specific Recommendations

- During operational deployment conditions
 - 'Unit watch' may be considered if hospitalization or evacuation is not possible.
- Otherwise, recommend against 'Unit watch'

Military-Specific Recommendations

- Periods of transition increase risk
- Ensure continuity of care during transitions
 - New duty station
 - After separation from unit
 - Separation from military service